STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155246	A. BUILDING 00 B. WING	08/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTERTON MANOR	110 BEVERLY DR CHESTERTON, IN 46304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey Dates: August 17, 18, 19, 20, and 21, 2015 Facility number: 000150 Provider number: 155246 AIM number: 100267000 Census bed type: SNF/NF: 76 Total: 76 Census payor type: Medicare: 15 Medicaid: 54 Other: 7 Total: 76 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	**The facility requests paper compliance for this citation.** The filing of this plan of correction does not constitute anadmission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.	
F 0170 SS=C Bldg. 00	483.10(i)(1) RIGHT TO PRIVACY - SEND/RECEIVE UNOPENED MAIL The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is unopened. Based on interview, the facility failed to	F 0170	F 170	09/11/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	ensure the residents received Saturday mail delivery. Finding includes: Interview with the Resident Council President on 8/20/2015 at 9:30 a.m., indicated the facility did not always deliver mail to the residents on Saturday. Interview with the Business Office Manager on 8/20/2015 at 10:00 a.m., indicated sometimes the postman did not deliver mail to the facility on Saturdays. She had repeatedly reported this to the post office and nothing had changed. Interview with the Administrator on 8/20/2015 at 10:37 a.m., indicated he was aware the postman did not always deliver the mail to the facility on Saturdays, and he had spoken to the manager of the post office regarding the matter. The Administrator indicated he would put a mailbox in front of the facility for the mailman to deliver on the weekend. 3.1-3(s)(1)		RIGHT TO PRIVACY-SEND/RECEIVE UNOPENED MAIL The resident has the right to privacy inwritten communications, including the right to send and promptly receive mailthat is unopened the facility did not always deliver mail to the residents on Saturday. As indicated during the Interview with theBusiness Office Manager during the survey of re-licensure that sometimes the postmandid not deliver mail to the facility on Saturdays. She had repeatedly reportedthis to the local post office and nothing had changed. The administratorindicated the postman was in fact not always consistent in the delivery ofresident mail to the facility on Saturdays, and that after repeated attempts tocorrect issue with postal delivery the Administrator put a mailbox in front ofthe facility for the mailman to deliver on	

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			weekends. The facility will monitor delivery of weekend mail and distribute Saturday mail via Manager assigned to week end shift. Averbal report of compliance will be given by at morning meetings by the weekend manager or a designee, on the following business day after the week end, atwhich time a record of compliance will recorded for review at QA meetings, inthe monitoring tool for compliance kept in the plan of correction book. Thiswill be reviewed 4 time a month weekly, for the first 3 months, and monthlythere after for three consecutive months. The facility alleges compliance on:September 11, 2015	
F 0247 SS=A Bldg. 00	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. Based on record review and interview, the facility failed to ensure a resident was	F 0247	**F247 483.12 Admission, Transfer and Discharge** **It is the practice of Chesterton**	09/11/2015

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	notified of a new roommate for 1 of 1 residents reviewed for a Admission, Transfer, and Discharge of the 1 resident who met the criteria for Admission, Transfer, and Discharge. (Resident #23) Finding includes: Interview with the Social Service Director on 8/20/2015 at 3:26 p.m., indicated she had spoken to Resident #23 about changing rooms, but not about getting a new roommate. Interview with the Admissions Director on 8/20/2015 at 3:38 p.m., indicated the resident should have received 24 hour notice of a new roommate. She further indicated there was no documentation Resident #23 was informed he was getting a new a roommate. Interview with Regional Director of Clinical Services on 8/20/2015 at 3:45 p.m., indicated the facility should have a policy regarding resident rights regarding their rooms. Review of Nursing Progress Notes and Social Service Progress Notes dated 8/1-8/20/15, indicated there was not any documentation regarding the facility notifying the resident of a new roommate		**Manor to ensure that eachresident is notified of receiving a new roommate.** **Upon an all resident admission review, it was determinedthat there was not sufficient notification of an in-coming roommate. It was determinedthat this only occurred during new admissions to the facility and that theAdmission Director will assist with notification of new admissions for appropriatedepartment heads at morning meetings.** **Resident #23 did not suffer any psychosocial distress fromreceiving a new roommate without notice and has since changed rooms perresident choice in order to be next to window.** **All residents have the potential to be affected.** **The facility has a policy in place addressing intra-facilitytransfers and admissions including informing residents of new roommates. Resident/family will be advised verballyand/or in writing via New Roommate Notification. Policy was reviewed with Admissions, SocialService Director, Director of Nursing and Administrator.** **In addition to the process noted above, the SSD and/or theAdmission Director is conducting a quality improvement audit to ensureresidents are monitored prior to receiving a new roommate. A random sample of 5 residents who havereceived new**	

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	being admitted to the residents room. Review of the current and undated policy "Your Rights As A Nursing Home Resident" provided by Regional Director of Clinical Services on 8/21/15 at 10:00 a.m., indicated ...Express preferences with respect to your room and roommate and be advised in writing before any changes are made. 3.1-3(v)(2)		**roommates will be monitored for the New Roommate Notificationforms monthly for 6 months. Date of Completion: 9/11/2015.**	
F 0314 SS=D Bldg. 00	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, record review and interview, the facility failed to ensure a resident admitted with a pressure ulcer received the necessary treatment and services to promote healing related to changing the treatment after no improvement for 1 of 3 residents reviewed for pressure ulcers of the 5 residents who met the criteria for	F 0314	**F 314 483.25(c) TREATMENT/SVCS TOPREVENT/HEAL PRESSURE SORES It is thepractice of Chesterton Manor to ensure that each resident who enters thefacility without pressure sores does not develop pressure sores unless theindividual's clinical condition demonstrates that**	09/11/2015

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	pressure ulcers. (Resident #39) Finding includes: On 8/19/15 at 12:25 p.m. Resident #39 was observed in bed. At that time, the resident had given consent for observation of the pressure ulcer treatment with the Nurse. At 2:20 p.m., the resident had refused the treatment. On 8/20/15 at 8:40 a.m., the resident was again observed in bed. At that time, the resident indicated she did not want anyone to look at her pressure ulcer. The record for Resident #39 was reviewed on 8/19/15 at 8:47 a.m. The resident's diagnoses included, but were not limited to, high blood pressure, depression, anxiety, stroke, diabetes, acute renal failure, dehydration, failure to thrive, and mild dementia. The Significant Change Minimum Data Set (MDS) assessment dated 5/9/15 indicated the resident had a Brief Interview for Mental Status (BIMS) of 9, which indicated she had moderate impairment for cognition. The resident had one Stage 3 pressure ulcer that was present on Admission. The 8/11/15 Significant Change MDS		**they were unavoidable; and aresident having pressure sores receives necessary treatment and services topromote healing, prevent infection and prevent new sores from developing fromany physical restraints imposed for the purposes of discipline or convenienceand not required to treat the resident's medical symptoms. I. Resident #39 had a pressure ulcer wound that had not improved over a six week period. II.Resident #39, residents with pressure ulcers and those at risk to be affected were assessed and no deficient practice was found. III.As noted in the survey report, the facility's new management has a policyregarding pressure areas. Staff have been re-educated on the new policy. IV.The DON, or her designee, is conducting quality improvement audits to ensurethat residents with pressure areas receive the necessary treatment and servicesto promote healing related to changing the treatment after no improvementnoted. This QI audit will be completed 3 times per week on three affectedresidents for 30 days; then monthly for 6 months. Results of these audits will be reported atthe QA committee**	

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	assessment that was currently in progress indicated the resident's BIMS score was now a 6 indicating she was not alert and oriented. The resident was readmitted from the hospital on 12/7/14 with a Stage 2 pressure ulcer to the sacrum. It measured 2.5 centimeters (cm) by 2.5 cm by .2 cm. The area was red with no slough or eschar (necrotic tissues) noted. On 4/6/15 the resident was admitted to the hospital. At that time, the pressure ulcer was still on the resident's sacrum and was last measured on 4/3/15 in which it measured .5 cm by .5 cm by .2 cm and was still a Stage 2 pressure sore. On 4/12/15 the resident was readmitted back to the facility. The pressure sore was now classified as a Stage 3 and measured 3 cm by 2.5 cm by .4 cm. The tissue was red and pink. There was a small amount of brown drainage noted. New treatment orders for calmoseptine ointment to the wound daily were obtained. A new Physician Order dated 4/19/15 and on the current 8/2015 recap, indicated cleanse wound to right sacral area with normal saline. Apply Fibrocol to wound bed, cover with Mepilex dressing once		**monthly. Appropriate nursing staff educated on policy 9/9/15.** **V. Date of completion: 9/11/2015**	

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	daily and as needed if soiled. The pressure ulcer was measured weekly and continued to improve until 7/6/15. The pressure ulcer weekly measurement record indicated the pressure ulcer was a Stage 3 and measured as followed: 7/6/15 .5 cm by .1 cm by .3 cm 7/13/15 .5 cm by .5 cm by .3 cm 7/20/15 .5 cm by .5 cm by .3 cm 7/27/15 .5 cm by .5 cm by .3 cm. The wound bed was red and pink. The Physician was notified and updated on the wound. No new orders were obtained. 8/1/15 .5 cm by .5 cm by .3 cm 8/6/15 .5 cm by .5 cm by .3 cm 8/14/15 .5 cm by .5 cm by .3 cm The wound bed was red and pink with no signs of necrotic tissue. The pressure ulcer wound had not improved over a six week period. The current and undated Pressure Ulcer Assessment and Staging policy provided by the Director of Nursing on 8/19/15 indicated "The Charge Nurse is responsible for care of pressure areas, The nurse is responsible to carry out the treatment protocol and report findings to			

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	the Director of Nursing/Designee." The Physician is to be notified when a pressure sore develops, if no improvement is noted after a reasonable amount of time, and/or upon signs of deterioration. The DON and nurses are to make pressure sore rounds every week and discuss each resident's progress and make necessary changes." Interview with ADON on 8/20/15 at 8:59 a.m., indicated the pressure ulcer was round. The area was pink and red with no eschar or slough. She indicated she was aware the pressure ulcer had not gotten any better and the treatment had remained the same over the last 6 weeks. She further indicated she was responsible for tracking the pressure ulcers and was aware of the facility's policy regarding to change the treatment if no improvement. Interview with the DoN on 8/20/15 at 3:20 p.m., indicated the new current policy by the new company does not have any information regarding taking care of the pressure ulcer after it had developed. She further indicated they were going to use the old policy by the previous owners until they get a new policy from the new corporation. 3.1-40(a)(2)			

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F 0329 SS=D Bldg. 00	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on observation, record review and interview, the facility failed to ensure a resident receiving a Psychotropic medication had a Gradual Dose Reduction (GDR) at least one time per year and behavior tracking and management was monitored to warrant an increase of medication related to Antipsychotic, Antianxiety, and Antidepressant medication for 3 of 5 residents reviewed for unnecessary	F 0329	**F329 483.25(l) DRUG REGIMEN IS FREE FROMUNNECESSARY DRUGS** It is thepractice of Chesterton Manor to ensure that each resident's drug regimen mustbe free from unnecessary drugs. An unnecessary drug is any drug when used inexcessive dose (including duplicate therapy); or for excessive duration; orwithout adequate monitoring; or without adequate indications for its use;	09/11/2015

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	medication of the 5 who met the criteria for unnecessary medication. (Residents #27, #82, and #63) Findings include: 1. The record for Resident #27 was reviewed on 8/19/15 at 9:54 a.m. The resident's diagnoses included, but were not limited to, psychosis, dementia without behavioral disturbance, anxiety, and Parkinson's disease. Physician Orders dated 5/14/15 indicated Lorazepam (Ativan) .5 milligrams (mg) 2 tabs every evening and Lorazepam .5 mg 8 a.m. and 12:00 p.m. Physician Orders dated 1/28/15 indicated Lorazepam .5 mg three times a day and on 2/25/15 that was to be discontinued and to start Lorazepam as above. The Quarterly Minimum Data Set (MDS) assessment dated 5/23/15 indicated the resident was not alert and oriented and received an Antianxiety medication 7 days a week. The resident had no mood problems. The resident had delusions but no hallucinations. Nurse's Notes dated 1/31/15 at 10:01 p.m., indicated the resident was still getting agitated in the late afternoon until		or inthe presence of adverse consequences which indicate the dose should be reducedor discontinued; or any combinations of the reasons above. I. Residents#27, #82, and #63 are prescribed antipsychotic medications. II. Residentsthat utilize antipsychotic medication have the potential to be affected. On9/9/15 all residents using antipsychotic medications were reviewed and no deficienciesfound. III. Thefacility has a behavior management policy in place. Licensed nurses and social service personnelhave been re-educated on this policy. This re-education stressed the continued importance of the provision ofnon-drug interventions prior to implementing psychoactive medications; and thecontinued use of the behavior monitoring record. The facility will also continue an IDTmeeting that includes the review of any behaviors and the interventionsutilized to manage those behaviors. IV.In addition to the process noted above, the SSD or her designee is conducting aquality improvement audit to ensure residents are monitored prior to theincrease of antipsychotic medication and that the indications for use as wellas the non-pharmaceutical actions are documented. A random sample	

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	after dinner and then begun to calm down and relax. Nurse's Notes dated 2/3/15 at 10:23 p.m., indicated the resident was still wiggly at the beginning of the shift and wanted to pull off his brief and kept setting his bed alarm off due to not being still. Nurse's Notes dated 2/8/15 at 3:11 p.m., indicated the resident continued to squirm and get out of the wheelchair. When assisted into bed resident continued to squirm and tried to get out. Nurse's Notes dated 2/8/15 at 10:53 p.m., indicated the resident appeared to be calmer during the day and relaxed at night. Continued review of Nurse's Notes indicated there were documented Nurse's Notes with no information of any type of increased behaviors or increased anxiety on 2/16 at 10:57 a.m. and 4:52 p.m., 2/20 at 2:24 p.m., 2/23 at 3:20 p.m., 2/24 at 5:41 p.m., and 2/25 at 2:53 p.m. Nurse's Notes dated 2/25/15 at 8:56 p.m., indicated MD (Medical Doctor) in to visit resident. New order increase Ativan .5 mg a.m., .5 mg at noon and 1 mg in p.m. The behavior monitoring record for the month of February 2015 indicated staff were to monitor the resident's behaviors of physical aggression and delusional		of 5 residents receivingpsychoactive medications will be monitored 3 times per week for 30 days; thenmonthly for 6 months. The pharmacyconsultant will assist in monitoring during monthly visits. Results of theseaudits will be reported at the QA committee monthly. Appropriate nursing staff educated on policy9/9/15. V.Date of completion: 9/11/2015	

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	thoughts or statements. The resident had no behaviors documented for that month, all the days were coded with zeros. Interview with the Social Service Director (SSD) on 8/19/15 at 1:38 p.m., indicated she looked at the behavior sheets everyday and kept a steno notebook in which she had tracked the resident's behaviors and reported them daily in the morning meetings. She indicated the resident had no documented behaviors in the month of February 2015. Interview with the Assistant Director of Nursing on 8/20/15 at 10:34 a.m., indicated the resident had no documented behaviors in the month of February 2015 to warrant the increase of the Ativan medication. 2. On 8/19/15 at 8:50 a.m. Resident #63 was observed ambulating by herself. The resident was mumbling things to herself. She was not observed with any psychotic episodes or increased anxiety. The record for Resident #63 was reviewed on 8/19/15 at 2:14 p.m. The resident's diagnoses included but were not limited to, Alzheimer disease, dementia, agitation and combative behavior, anxiety, insomnia, Alzheimer dementia with agitated behavior.			

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Physician Orders dated 5/1/15 and on the current 8/2015 recap indicated Lorazepam (Ativan an Antianxiety medication) .5 milligrams (mg) at night time. Another Physician Order dated 11/1/13 and on the current 8/2015 recap indicated Mirtazapine (Remeron an Antidepressant medication) 7.5 mg at night time. A Physician Order dated 12/3/12 indicated Quetiapine (Seroquel an Antipsychotic medication) 50 mg twice a day at 9 a.m. and 5 p.m. with 100 mg to equal 150 mg of Seroquel twice a day.

The Annual Minimum Data Set (MDS) assessment dated 5/6/15 indicated the resident was severely impaired for decision making with short and long term memory problems. The resident had behaviors of wandering and verbal behaviors directed toward others and staff. The resident received an Antianxiety, Antidepressant, and Antipsychotic medications 7 days a week.

The Behavioral Care Solutions report prepared by a contracted service and a Nurse Practitioner dated 9/4/14 indicated the resident was currently receiving Remeron 7.5 mg at night time, Ativan .5 mg at night time and Seroquel 150 mg twice a day. Continue Ativan .5 mg for

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	anxiety GDR 3/13 and failed 6/13, continue Seroquel for reduction of psychosis and continue Remeron 7.5 mg for mood stabilization appetite and sleep. "Since her Seroquel was increased in November 2011, her behaviors are less intense and more re-directable. She experiences improved sleep hygiene on Remeron. Her pacing continues but it is less intrusive and more easily redirected. GDR of Ativan attempted in March 2013. Patient with increase in yelling behaviors this past few months resulting in increasing Ativan but patient becoming to sedated on higher doses." The Behavioral Care Solutions reports dated 10/7/14 and 12/11/14, were all prepared by same Nurse Practitioner as above. The exact same information was documented on all two of those visits with no new information regarding behaviors or GDR's. The Behavioral Care Solution report dated 2/21/15 was by a different Nurse Practitioner. The report indicated the patient was a younger but advanced Alzheimer dementia patient who wanders hallways talking to herself and others. Since her Seroquel was increased in November 2011 her behaviors were less intense and more re-directable. The patient experienced improved sleep			

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	hygiene on Remeron, but her pacing continues but it was less intrusive and more easily redirected. A GDR of Ativan was attempted in March 2013 but the patient was with increased yelling behaviors this past few months resulting in increasing Ativan. In follow up, staff reports continued pacing and mumbling to herself. She cursed at staff and will occasionally grab chairs in the dining hall and growl. Her behaviors were re-directable. The Behavioral Care Solution report dated 4/27/15 had the exact information as above but had the recommendation to consider a GDR for the Remeron and discontinue it all together. Nurse's Notes were reviewed and documentation of any type of behavior were as followed: On 2/26/15 at 3:26 p.m., "Nurse was informed this shift resident with increased yelling and growling at times throughout this shift occurred 5-6 times an hour." On 3/4/15 at 11:34 a.m., "Reviewed in IDT continue to monitor resident for wandering and resident making growling noises. Last week there was an increase noted with resident growling." Physician was notified and Urinalysis was ordered.			

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	The resident was started on an antibiotic for an Urinary Tract Infection." On 4/28/15 at 2:46 p.m., "Discussed in behavior meeting. Spoke with husband regarding psych services recommendation to discontinue Remeron. Husband stated that he would talk to his wife's primary care Medical Doctor." Continued review of Nurse's Notes for the months of May, June, July and up until 8/20/15 indicated there was no other information regarding the discontinuation of the Remeron or any behaviors. Nurse's Notes dated 8/5/15 at 12:49 a.m., indicated no episodes of increased anxiety. Received scheduled Ativan and continued to wander the facility halls. Remains unaware of safety and can be combative with care at times. Displays behaviors of clapping hands, singing and occasion utter curse words. The behavior monitoring sheets from January 2015 to July 2015 were reviewed. The facility was monitoring the resident's behaviors of wandering, yelling and growling. The resident had been receiving the same dosage of Seroquel for two years and eight months with no documented			

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	episodes of any type of psychotic behaviors. The resident had been receiving the Remeron for one year and nine months and the current recommendation by the Nurse Practitioner had not been followed through. Interview with the DoN on 8/20/15 at 2:00 p.m., indicated Social Services takes care of the GDR's. Interview with the Social Service Director (SSD) on 8/20/15 at 2:05 p.m., indicated she took care of the GDR's. She indicated they were waiting on a new Nurse Practitioner from the Behavioral Solutions Company to come to see the residents. She indicated the resident had behaviors such as making loud growling noises, clapping of her hands on her thighs, and intrusive wandering. She was unaware of any combative behaviors or verbal outbursts directed toward others and staff. She indicated her behaviors were more worsened after supper and towards the evening. The SSD indicated after supper the resident would not let you escort her out of the dining room without resistance. She indicated the resident had not had any psychotic episodes since she had been at the facility and that would be from January 2015 until present. She further indicated the			

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	resident had not had GDR for the Seroquel since 2012, nor the Remeron since 2013. 3. The record for Resident #82 was reviewed on 8/20/15 at 10:00 a.m. The resident's diagnoses included, but were not limited to, dementia with behavior disturbances and depression. A Physician's Order dated 10/9/14 indicated Sertraline (an anti-depressant medication) 50 milligrams (mg) by mouth once daily and Seroquel (an anti-psychotic medication) 25 mg at bedtime. The current plan of care indicated the resident was at risk for adverse side effects associated with psychotropic medication daily use. The approaches included, but were not limited to, medications as ordered, monitor every shift for side effects and effectiveness, and explain to family ongoing need to ensure least possible dosing-gradual dose reductions. The Quarterly Minimum Data Set (MDS) assessment dated 5/2/15 indicated the resident's Brief Interview for Mental Status (BIMS) score was a 3 indicating she was severely cognitively impaired. The resident was coded as having no			

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	behaviors. The resident's medications included, but were not limited to anti-psychotic and anti-depressants. There was no evidence of documentation indicating the resident had been recommended a gradual dose reduction for the use of her anti-depressant and or anti-psychotic medications in the last year. Interview with the Social Service Director on 8/21/15 at 10:11 a.m., indicated she meets with the Pharmacist monthly and she was also involved in monthly behavior meetings. During her meetings she cross references the residents with the current Physician's orders to ensure all residents' medications were addressed, however, Resident #82's medications had not been addressed and she did not have any attempts of gradual dose reductions in the last year. The Behavior Management/Psychotropic Medication Committee Agenda policy dated 1/2007 indicated, "When applicable, the committee will recommend gradual dose reductions of anti-psychotic, antixiolytic and sedative/hypnotic medications unless contraindicated in an effort to decrease or discontinue these drugs."			

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	The current Psychoactive Medications policy dated 5/2013 indicated, "Gradual Dose Reductions (GDR) should be attempted within the first year in which a resident is admitted on medications or after medication is initiated. A second GDR should be attempted in a separate quarter at least one month following initial GDR then annually thereafter unless clinically contraindicated." 3.1-48(b)(2)			
F 0431 SS=D Bldg. 00	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the			

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	keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, record review and interview, the facility failed to ensure multi dose vials of insulin and/or insulin pens were dated when opened for 2 of 4 medication carts throughout the facility. (The 200 and 300 hall medication carts) Finding includes: On 8/21/15 at 11:43 a.m., one vial of Novolog insulin was not dated when opened in the 200 hall medication cart. Interview with LPN #1 at the time, indicated the vial of insulin should have been dated when opened. At 11:47 a.m., two vials of Lantus insulin, a vial of Humulin R insulin and two Humalog insulin flex pens were not dated when opened in the 300 hall medication cart. Interview with RN #1 at the time,	F 0431	**F 431 483.60(b), (d), (e) DRUGRECORDS, LABEL/STORE DRUGS & BIOLOGICALS** It is the practice of Chesterton Manor to employ or obtain the services of alicensed pharmacist who establishes a system of records of receipt anddisposition of all controlled drugs in sufficient detail to enable an accuratereconciliation; and determines that drug records are in order and that anaccount of all controlled drugs is maintained and periodically reconciled. Drugsand biologicals used in the facility must be labeled in accordance withcurrently accepted professional principles, and include the appropriateaccessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws,the facility must store all drugs and biologicals in locked compartments underproper temperature controls, and permit only authorized personnel to haveaccess to the keys. The facility mustprovide separately locked,	09/11/2015

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	indicated the vials of insulin and the flex pens should have been dated when opened. The facility policy titled "Vials and Ampules of Injectable Medications Policy" provided by the Director of Nursing on 8/21/15 at 1:10 p.m. and identified as current, indicated the following: "the date opened and the initials of the first person to use the vial are recorded on multi-dose vials on the vial label or an accessory label affixed for that purpose." 3.1-25(j)		permanently affixed compartments for storage ofcontrolled drugs listed in Schedule II of the Comprehensive Drug AbusePrevention and Control Act of 1976 and other drugs subject to abuse, exceptwhen the facility uses single unit package drug distribution systems in whichthe quantity stored is minimal and a missing dose can be readily detected. 1.Multi dose vials of insulin and/or insulin pens werenot dated when opened for 2 of 4 medication carts throughout thefacility. 2.Residents who receive multi dose vial and/or insulinpen medication. 3.As noted in the survey report, the facility has apolicy regarding vials and ampules of injectable medications. 4.The DON, or her designee, is conducting qualityimprovement audits to ensure multi dose vials of insulin and/or insulin pensare dated when opened. The QI audit willbe completed 3 times per week on 4 medication carts for 30 days; then monthlyfor 6 months. Results of these auditswill be reported to the QA committee monthly. Any negative findings will add another 4 weeks of audits until 100%compliance is achieved. 5.Date of completion: 9/11/2015	
F 0441 SS=E Bldg. 00	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS			

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	The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on observation, record review, and interviews, the facility failed to ensure there was an infection control program that monitored, tracked and trended, all	F 0441	**F 441 483.65 INFECTION CONTROL,PREVENT SPREAD, LINENS** **It is the practice of Chesterton Manor toestablish and maintain**	09/11/2015

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	Nosocomial and non Nosocomial infections. Finding includes: On 8/20/15 at 3:00 p.m., the infection control logs were reviewed. At that time, the infection control logs for 1/15, 2/15, 3/15, 4/15, 5/15, 6/15 indicated the logs were incomplete and not accurately completed. The 1/15 and 2/15 logs indicated no documentation of infection/related diagnosis, what type of culture was done, organism found, antibiotic, if the infection was isolated, and if it was Nosocomial or not. The 3/15 and 4/15 logs indicated no documentation of what type of culture was done, organism found, antibiotic, if the infection was isolated, and if it was Nosocomial or not. The 5/15 logs indicated no documentation of infection/related diagnosis, what type of culture was done, organism found, if the infection was isolated, and if it was Nosocomial or not. The 6/15 logs indicated no documentation of what type of culture was done, if the infection was isolated,		**an Infection Control Program designed to provide a safe,sanitary and comfortable environment and to help prevent the development andtransmission of disease and infection.** 1. The facility did not ensure there was aninfection control program that monitored, tracked and trended, all Nosocomialand Non Nosocomial infections. 2. All residents were reviewed for currentinfection initiated track and trending for nosocomial and Non nosocomial to beadded to QA monthly. 3.As noted inthe survey report, the facility has an infection control policy addressinginfection control. 4.TheDON, or her designee, is conducting quality improvement audits to ensure nosocomialand Non Nosocomial are being monitored, tracked, and trended. The QI audit willbe completed 3 times per week on 5 random residents for 30 days; then monthlyfor 6 months. Results of these auditswill be reported to the QA committee monthly. The DON, or her designee, isconducting quality improvement audits to ensure multi dose vials of insulinand/or insulin pens are dated when opened. The QI audit will be completed 3 times per week on 4 medication cartsfor 30 days; then monthly for 6 months. Results of these audits will be reported to the QA committee monthly.	

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	and if it was Nosocomial or not. There were no 7/15 or 8/15 logs available for review. Further review of the 1/15, 2/15, 3/15, 4/15, 5/15, 6/15 infection control logs, indicated there was no evidence of any documentation for tracking and trending the resident's patterns and/or infections per hall. Interview with the Director of Nursing on 8/21/15 at 9:42 a.m., indicated she was aware the infection control logs were not accurately completed and there had been no tracking or trending of the resident's patterns and/or infections per hall. Continued interview indicated the concern had been addressed through the Quality Assurance Program and there was a plan of action put into place. The current Policies and Practices-Infection Control policy indicated, "....maintain records of incidents and corrective actions related to infection." 3.1-18(b)(1)		Appropriatenursing staff educated on policy 9/9/15. 5.Date ofcompletion 9/11/2015 ~ F 441 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS It is the practice of Chesterton Manor to establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. 1.The facility did not ensure there was an infection control program that monitored, tracked and trended, all Nosocomial and Non Nosocomial infections. 2.All residents were reviewed for current infection initiated track and trending for nosocomial and Non nosocomial to be added to QA monthly. 3.As noted in the survey report, the facility has an infection control policy addressing infection control. 4.The DON, or her designee, is conducting quality improvement audits to ensure nosocomial and Non Nosocomial are being monitored, tracked, and trended. The QI audit will be completed 3 times per week on 5 random residents for 30 days; then monthly for 6 months. Results of these audits will be reported to the QA committee monthly. The DON, or her designee, is conducting quality	

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			improvement audits to ensure multi dose vials of insulin and/or insulin pens are dated when opened. The QI audit will be completed 3 times per week on 4 medication carts for 30 days; then monthly for 6 months. Results of these audits will be reported to the QA committee monthly. Appropriate nursing staff educated on policy 9/9/15. 5.Date of completion 9/11/2015	
F 0465 SS=E Bldg. 00	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to provide a functional and sanitary environment related to marred walls, marred doors, urine odors, stained floor tile and cracked base boards on 4 of 4 halls throughout the facility. (The 100, 200, 300 and 400 halls) Finding includes: During the Environmental Tour on 8/21/15 at 9:10 a.m., with the Housekeeping and Maintenance Supervisors, the following was observed: The 100 hall a. The inside of the bathroom door and the door frame were paint chipped and	F 0465	F 465 SAFE/FUNCTIONAL/SANITARY /COMFORTABLE ENVIRON The facility must provide a safe,functional, sanitary, and comfortable environment for residents, staff and thepublic. Marred walls, marred doors, urine odors,stained floor tile and cracked base boards on 4 of 4 halls throughout thefacility. In general areas of deficiency were identified as beginning presenton the following resident halls: Hall100, 200, 300 and 400.	09/11/2015

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	marred in Room 106. Two residents resided in this room. The 200 hall a. The wall next to bed one in Room 203, was scratched and marred. The inside of the bathroom door was also scratched and marred. Two residents resided in this room. b. The inside of the bathroom door was scratched and marred in Room 209. Two residents resided in this room. c. The bathroom door in Room 210 was scratched and marred. Two residents resided in this room. d. The bathroom door in Room 212 was scratched and marred. Two residents resided in this room. The 300 hall a. The inside of the bathroom door as well as the door frame was scratched and marred in Room 301. The floor tile in front of the toilet as well as around the toilet, was discolored. A bolt next to the toilet near the floor was rusted. Two residents resided in this room. b. There was a strong urine odor in the		Resident rooms wereidentified as specific to.., 1.) The100 hall. a.) The inside of the bathroom door and thedoor frame were paint chipped and marred in Room 106. Two residents resided inthis room. Maintenance has fixed and repainted door frames and doors, installedkick plates on the inside and outside of bathroom door and scuff resistantmaterial on door frame. 2.) The 200 hall. a.) The wall next to bed one in Room 203, was scratched and marred. Theinside of the bathroom door was also scratched and marred. Two residentsresided in this room. Maintenance has fixed and repainted door frames and doorsand installed kick plates on the inside and outside of bathroom door and scuffresistant material. b.) The inside of the bathroom door was scratched and marred in Room209. Two residents resided in this room.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTERTON MANOR	110 BEVERLY DR CHESTERTON, IN 46304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	bathroom of Room 306. The floor tile beneath the toilet was rusted as well as the bolts securing the toilet. Two residents resided in this room. c. The inside of the bathroom door in Room 307 was scratched and marred. Two residents resided in this room. The 400 hall a. The bathroom door in Room 406 was scratched and marred. Two residents resided in this room. b. The bathroom door in Room 408 was scratched and marred. There was an area of cracked base board and chipped paint on the wall by the bathroom. Two residents resided in this room. c. The bathroom door in Room 412 was scratched and marred. One resident resided in this room. Interview with the Maintenance Supervisor on 8/21/15 at 9:30 a.m., indicated all the above was in need of cleaning and/or repair. 3.1-19(f)		Maintenance has fixed and repainteddoor frames and doors and installed kick plates on the inside and outside ofbathroom door and scuff resistant material on door frame. c.) The bathroom door in Room 210 was scratched and marred. Tworesidents resided in this room. Maintenance has fixed and repainted door framesand doors and installed kick plates on the inside and outside of bathroom doorand scuff resistant material on door frame. d.) The bathroom door in Room 212 was scratched and marred. Tworesidents resided in this room. Maintenance has fixed and repainteddoor frames and doors and installed kick plates on the inside and outside ofbathroom door and scuff resistant material on door frame. 3.) The 300 hall. a.) The inside of the bathroom door as well as the	

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			door frame wasscratched and marred in Room 301. The floor tile in front of the toilet as wellas around the toilet, was discolored. A bolt next to the toilet near the floorwas rusted. Two residents resided in this room. Maintenance has resealed withepoxy paint sealant underlayment and replaced flooring in bathroom replacingrusty bolts. Maintenance has fixed and repainted door frames and doors andinstalled kick plates on the inside and outside of bathroom door and scuffresistant material on door frame. b.) There was a strong urine odor in the bathroom of Room 306. The floortile beneath the toilet was rusted as well as the bolts securing the toilet.Two residents resided in this room. Maintenance has resealed with epoxy paintsealant underlayment and replaced flooring in bathroom, replacing rusty bolts,as well as repainted door frames and doors. Housekeeping will	

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			affect thenecessary deep cleaning of room306 for correction of any additional urineodors. c.) The inside of the bathroom door in Room 307 was scratched andmarred. Two residents resided in this room. Maintenance will repair and replaceas needed cracked cove-base. Maintenance fixed and repainted door frames anddoor and installed kick plates on the inside and outside of bathroom door andscuff resistant material on door frame. 4.) The 400 hall a.) The bathroom door in Room 406 was scratched and marred. Two residentsresided in this room. Maintenance has fixed and repainted door frames and doorsand installed kick plates on the inside and outside of bathroom door and scuffresistant material on door. b.) The bathroom door in Room 408 was scratched	

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			and marred. There was anarea of cracked base board and chipped paint on the wall by the bathroom. Tworesidents resided in this room. Maintenance has repaired and replaced as neededcracked cove-base. Maintenance has fixed and repainted door frames and doorsand installed kick plates on the inside and outside of bathroom door and scuffresistant material on door frame. c.) The bathroom door in Room 412 was scratched and marred. One residentresided in this room. Maintenance has fixed and repainted door frames and doorsand installed kick plates on the inside and outside of bathroom door and scuffresistant material on door frame. Interview with the Maintenance Supervisor duringsurvey indicated all the above was in need of cleaning and/or repair. Housekeepinghas completed the necessary deep cleaning of rooms affected for	

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			correction ofany additional urine odors. Maintenance and will complete a list of the roomsrepairs for recording purposes for rooms Identified by upcoming audits. An audit tool will be kept of weekly roomaudits. Weekly room audits for three random rooms will be conducted for 4weeks, three consecutive months, and monthly once a month thereafter for threeconsecutive months of room ascetics and paint conditions. A record of maintenancefor room repairs will be kept for this period of all work completed in the planof correction book. This record will becompleted by maintenance, the administrator, or a designee.	
F 0520 SS=D Bldg. 00	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to			

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	identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. Based on interview and record review, the facility failed to identify the non-compliance of Gradual Dose Reductions (GDR) related to Antipsychotic, Antidepressant, and Antianxiety medications through the facility's quality assurance protocol. Finding includes: Interview with the Administrator on 8/21/15 at 1:15 p.m., indicated the quality assurance committee meets on a monthly basis. The committee consists of himself, the Director of Nursing (DoN), the Assistant Director of Nursing (ADoN) and all the other department managers. He indicated the Physician, Pharmacist, Registered Dietician, and other ancillary services meet with the facility on a quarterly basis.	F 0520	F520 – 483.75 QAA Committee members / Meet quarterly / Plans It is the practice of Chesterton Manor to maintain a qualityassessment and assurance committee consisting of DON, Physician designated bythe facility, and at least 3 other members of the facility staff. Residents that utilize antipsychotic medications have thepotential to be affected. Gradual dose reductions (GDR) related to antipsychotic,antidepressant, and antianxiety medications will be included in the facilityquality assurance protocol. The policy is in place to include GDR in the monthly qualityassurance meeting. Social ServicesDirector will report GDR statistics from the Pharmacy Consultant at the monthlymeeting. All quality assurance staff have been educated on the policy.	09/11/2015

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	The Administrator indicated the committee does discuss Psychotropic medication, however, GDR's were not addressed. The Administrator indicated the Social Service Director had been at the facility for the last eight months and was currently in charge of monitoring and tracking the GDR's, however, she really was not aware of all the Psychotropic medication. He further indicated Nursing services had not been involved with GDR's and currently provided no help with tracking and monitoring the reductions of the Psychotropic medication. Interview with the DoN on 8/20/15 at 2:00 p.m., indicated Social Services takes care of GDR's. Interview with the Social Service Director (SSD) on 8/20/15 at 2:05 p.m., indicated she took care of GDR's. She indicated they were waiting on a new Nurse Practitioner from the Behavioral Solutions Management Company to come to see the residents. Further interview with the SSD, indicated every morning she tracks and monitors the resident's behaviors from the behavior flow sheets and documents them in a steno notebook. She then takes the information to the morning meetings for discussion. She indicated the facility had			

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	just switched Pharmacists, so she would be working more closely with them. 3.1-52(b)(2)			